Côte d'Ivoire Resource Moblization: Executive Summary

Ministry of Public Health

National Institute of Public Health, Côte d'Ivoire

Data for Decision Making Project
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Data for Decision Making

The Data for Decision Making (DDM) Project was established in 1991 at Harvard University as a consortium with the Research Triangle Institute and Intercultural Communication, Inc, and with support from the United States Agency for International Development. The mission of the project is to work with governments and their senior decision makers to develop national capacities to manage health sector reform. Development of health sector capability requires making optimal use of available data and advanced analytical techniques to identify problems, develop policy, and strengthen management in the health care sector.

In the 1990s, health systems worldwide face a multitude of challenges: providing services for all, responding to the needs of growing and aging populations, and sustaining the child survival gains achieved in the 1980s. Governments and their Ministries of Health increasingly call for health sector reform to provide quality services more efficiently, to reduce inequalities, and to develop new linkages between the private and public sectors.

The DDM project works with countries by making its technical staff available for fact-finding or advisory visits. Host country officials and DDM project experts develop mutually agreeable problem-solving strategies. DDM tools and studies include: priority setting and cost-effectiveness analysis; political mapping; national health accounts; private-public sector linkages; geographic information systems; research communication; budget tracking system; and democracy and health.

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Cote d'Ivoire Resource Mobilization

Executive Summary

Resource mobilization in the health sector of Cote d'Ivoire is influenced by actors at various levels of the public and private sectors. In the public sector are the major institutional actors, including the Ministry of Health (MOH), the Ministry of Planning and Industrial Development (MOPID), and the Ministry of Industry of the Interior and National Integration (MOINI). In the private sector the insurance companies -- the CNPS (Caisse Nationale de Prevoyance Sociale), and the MUGEF-CI (Mutuelle generale des Fonctionnaires et Agents de l'Etat - Cote d'Ivoire) -- are highly influential actors in resource mobilizaition. In addition, ever since 1972 when the FRAR (Fonds Regionaux d' Amenagement Rural Social) was established, households have participated indirectly in the financing of the health system, particularly with the introduction of cost recovery programs. In addition, a strong and complex social network involves the population in significant ways in the mobilization and redistribution of resources. Finally, it should be noted that drugs are purchased through both public and private sources.

Public Sector Expenditure

In 1995, on an approved budget of close to 80 billion CFA, the MOH spent approximately 63 billion CFA or 80% of the budget, and the MOPID raised 1.6 billion CFA through the FRAR. The MOINI augmented the funding available for the health sector by allocating an averge of 450,000 CFA per ***commune*** annually. This expenditure was calculated before the creation of 61 new rural ***communes***, which increased the number of *communes* in Cote d'Ivoire from 135 to 196. On the assumption that the increase in the number of ***communes*** does not affect the average expenditures per ***commune*** (i.e, the new ***communes*** are subject to the same rules as the old ones), the ***communes*** spend 88 million CFA for health care per year.

Private Sector Expenditure

The private sector is principally represented by the private insurance companies, the MUGEF-CI, the CNPS, and the FSU-COM. However, since the FSU-COM is limited in scope, it cannot be considered a mechanism for resource mobilization on a national scale. Between 1991 and 1994, the annual growth rate of premiums recovered by private companies was 10.7%, an increase of 4.7% for claims paid in previous years. The value of premiums thus collected in 1995 is estimated at 8.6 billion CFA, of which 6.4 billion CFA was disbursed in benefit payments. The MUGEF is attempting to level off its expenditures for services at a level of 6 billion CFA. Finally, the ***branche maladie*** or health division of the CNPS (AT/MP and receipts from the Medico Social Centers), collected fees totaling about 3.5 billion CFA.

Cost Recovery

In its modern form (decree 93-216 of February 3, 1993), cost recovery is considered an innovation, while all other methods of financing detailed here have been in place for many years.

Mobilization of Funds

The analysis of cost recovery in Cote d'Ivoire has been facilitated by the development of a performance indicator--"the coeffecient of mobilization" -- which compares the total collection of fees by facilities with the amount of public funds allocated to them. It is generally observed that the payment recovered from users is proportional to the budget allocation received from the MOH. The central budget has both an "incentive" and "disincentive" effect on health facilities. The "incentive" effect is that despite the low level of public funds allocated to them, health facilites generate a large volume of their own resources. This is the case in the East Central and Southwest regions where the mobilization coefficients are .73 and .54 respectively. On the other hand, there is also a "disincentive" effect, especially regarding health training. These programs benefit from significant public contributions, they have little incentive to mobilize their own resources well. The level of the State's contribution seems to negate the ability of the health facilities to fully realize the potential of cost recovery activities. This is the case in the North Central and North regions, where the coefficients of mobilization are .20 and .30 respectively.

Allocation of Resources

A second aspect of analyzing cost recovery is its impact on resource allocation. It is found that financial managers of health organizations which have access to governmental and non-governmental sources of income do not substitute one source of income for another. Instead, the income budget reinforces preexisting tendencies of public-money spending, rather than providing formulas for substitution. Thus a comparison of the two types of spending--the income budget and the public-money budget--made on the basis of two trial regions (Central-East and Central-North), reveals that both kinds are organized around a dominant scheme that includes daily expenses, technical equipment, office supplies and maintenance of equipment.

Quality of Care

Last but not least is quality of care. Though the study did not conduct surveys to evaluate the satisfaction of the population, there has been an attempt to determine to what extent cost recovery can be used as an investment for promoting quality of care. Responses to questions regarding the incidence of resource allocation indicate that, in general, the dimension of quality seems to be recognized. An indicator was used to refine the analysis represented by the ratio: expenditure for budget for own resources/public budget expenditures (ratio calculated by function of expenditure). This indicates the proportion to which the expenditure of Budget for own Resources covers the expenditure of BGF. The ratio is highest for technical supplies: .58 for Central-East health facilities and .31 for Central-North health facilities. Therefore, without testing the conclusion in the

field by evaluating, for example, the availability of small supplies/equipment and medical products or the cleanliness of buildings and equipment, the conclusion is that the quality improved significantly with the introduction of cost recovery. It therefore appears that the financial influx really translates into physical benefits in terms of quality of care.

Between October, 1994, and June, 1996, the total fees collected by urban health facilities shows a tendency to level off in the context of cost recovery: 439 million CFA were recovered during the last trimester of 1994, versus 417 million CFA between January to March, 1996, and 383 million CFA between April and June, 1996. This stagnation, coupled with the gains made in increased utilization of publicly-mobilized resources, clearly illustrates the importance of personnel motivation and incentive systems to maximize the return on the cost recovery strategy in the public health care system. It is thus appropriate to revise the rules governing cost recovery by fees, and to increase autonomy and resources at the local level while suppressing the portion of cost recovery currently reserved for the Treasury. Serious reform of working conditions for health professionals is necessary to improve personnel motivation. Because the current system is felt by the majority to be so inequitable, the only motivation people have is to use the dysfunctional system to their advantage.

Private Actors

There are many constraints and obstacles on private actors. The FSU-COM is interested in public health only if it is able to increase its staffing. Furthermore, many strong and contradicting individual rationales and strategies coexist within the structure. Financial stability particularly influences the behavior and orientation of researchers, who in turn influence the sustainability of control within the structure. According to M. Bangoura, Secretary-General of the MOH in Guinea, "The action of the management committee for health facilities is, above all, polarized on financial management to the detriment of social mobilization."

Given the current state of affairs, the private insurance companies are presently not interested in playing a more active role in resource mobilization for health care. For them, illness is nothing but a product and the ***branche maladie*** a dead weight rather than a source of financial gain. The losses accumulated in 1991, 1992, and 1993 illustrate the danger in managing this risk: -1.3 billion, -233 million, and -1.1 billion CFA, respectively. Mobilization of resources by the CNPS underlines the absence of a defined political consensus between employers and the unions. The CNPS limits itself to work-related accidents and illnesses despite the existence of health care programs, which are being developed but which currently have have a relatively limited scope. At the same time, the companies provide for important health care expenditures for their employees outside of the CNPS circuit. It is evident that the rationale used cannot pass for a real policy. Finally, a significant limitation of the CNPS is that it reaches only active salaried staff. The foreseen trends of the labor market in Africa are moving toward growth in the informal sector, rather than in the expansion of salaried labor. The MUGEF's situation this calls into question the issue of protection of the State and of management autonomy and

financial risk. Given the current situation, it seems that a strategy for mobilizing resources based on socio-professional categories is incompatible with a more general strategy for achieving a coherent public health policy and guaranteeing financial stability. Such a strategy would lead to personnel issues, including inter-professional relations and redistribution of employees.

Finally, it is obvious that in order to be cost-effective and to improve the access to care for the poor, all strategies of resource mobilization must include research on new practices for importing and distributing medicines. One reform would be to amend the existing legal and regulatory framework to allow non-traditional actors, such as the PSP and the private wholesale distributors, to import and distribute drugs.